Past Ocular History (Please circle any eye conditions that you had/have)

Amblyopia (lazy eye)	Cataracts	Floaters	Retinal detachment
Macular Degeneration (Dry)	Diabetic Retinopathy	Glaucoma	Retinal tear
Macular Degeneration (Wet)	Diplopia (double vision)	Glaucoma suspect	
Blepharitis	Dry eyes	PVD (Vitreous detachment)	**Other:**

Past Ocular Surgeries / Procedures (Please circle)

No prior eye surgeries	Cataract surgery R L	Glaucoma surgery	Retinal detachment repair
Eyelid surgery	Corneal transplant	LASIK	
YAG (laser after cat surgery)	Glaucoma Laser	RK incisions	Other:

Systemic Infections (Please circle any infections that you had/have)

Histoplasmosis	Hepatitis	Shingles	Tuberculosis
HIV positive	Herpes Simplex Virus	Syphillis	Other:

Systemic Illnesses (Please circle any systemic illness you had/have)

Anemia	Cancer	Headache	Hyperthyroidism
Asthma	Diabetes, Type I	Heart Disease	Migraine
Anesthesia complications	Diabetes, Type II Meds/Insulin	High blood pressure	Multiple Sclerosis
Arrhythmia	Emphysema	High cholesterol	Polymyalgia
Atrial Fibrillation	GERD	History of stroke	Rheumatoid Arthritis
Basal Cell carcinoma	Gout	Hyperlipidemia	Thyroid Disease
Bleeding Disorder	Graves Disease	Hypertension	Other:

Head / Ocular Trauma (Please circle)

No head trauma	No ocular trauma	Trauma (type/date):

General surgeries (Please circle any surgeries you have had)

No prior surgeries	Coronary Artery Bypass	Hip replacement	Pacemaker implant
Aortic valve surgery	Gallbladder	Hysterectomy	Prostate surgery
Appendectomy	GI surgery	Kidney/Pancreas transplant	Status post angioplasty
Back surgery	Heart transplant	Knee replacement	Thyroidectomy
Carotid surgery	Heart Stents	Mastectomy	Tonsillectomy
Colectomy/Colon surgery	Hernia repair	Mitral valve surgery	Other:

Allergies (Please list any allergies and your reaction to the allergen)

None	Penicillin Y N Reaction:	Other:
	Latex Y N Reaction:	Reaction:
	Sulfa Y N Reaction:	

Family History (Please circle if your (M)other, (F)ather or (S)ibling has any of these conditions)

Adopted	Blindness M F S	Retinitis Pigmentosa M F S
Amblyopia M F S	Glaucoma M F S	Macular Degeneration M F S

Alcohol Use **Smoking**

No alcohol/drug use	Moderate every day		Non-smoker	Smokes cigarettes
Occasional	Heavy drinker		Quit smoking	Smokes controlled substances
Social	Quit drinking		Smokes cigars	Chewing tobacco

Name: _____ Primary Care Doctor: _____

Pharmacy you use for medications: _____ Intersection:_____Phone: _____